CABINET DENTAIRE

Dr. S. Gawellek et Associés

ANAMNESIS

Dear patient!

For optimal dental treatment, an accurate history of your health condition is necessary. Therefore, we ask you to fill out this form.

Patient:

First name _____ Phone privat _____

Last name _____ Phone mobile _____

Street, Nr. _____ Phone work _____

ZIP, City _____ E-Mail _____

Social security number _____ Country _____

◯ Insurance _____ ◯ Dental insurance _____

I am self-insured ◯ yes ◯ no

If not:

Legal representative:

Last name _____ Phone privat _____

First name _____ Phone mobile _____

Street, Nr. _____ Phone work _____

ZIP, City _____ E-Mail _____

Social security number _____ Country _____

◯ **Treating general practitioner** ◯ **Treating pediatrician**

Full Name _____ Phone privat _____

Street, Nr. _____ Phone mobile _____

ZIP, City _____

I acknowledge that the data or findings of my medical history, including X-rays and photos, their copies or printouts, will be exchanged with my doctor or other persons subject to medical confidentiality, such as insurance companies, etc., for the purpose of any necessary clarifications or information, and that the data required for invoicing, collection and accounting will be forwarded to the institutions involved.

Date: Signature:

In order to provide you with the best possible therapy, various treatments, such as composite fillings, ˜ KFO (orthodontics), root canal treatment, laser surgery, fabrication of esthetic temporaries, etc., may incur additional costs (CP8)that are not covered by your health insurance. If this is the case for you, we will inform you about it before the treatment.

Date: Signature:

I agree to be given local anesthesia if necessary (local anesthesia). I am aware that in very rare cases irritation may occur in the lower jaw and tongue (persistent numbness, tingling), which usually disappears. I acknowledge that there is an increased risk of accidents for several hours after dental surgery under local anesthesia when actively participating in road traffic.

Date: Signature:

- Do you take medication regularly? If yes, which ones? ◯ yes ◯ no

Are you taking **bisphosphonates**? ◯ yes ◯ no
Are you taking **blood thinning medication**? ◯ yes ◯ no

- Do you have any known allergies? If yes, which ones? ◯ yes ◯ no

- Are you/were you recently receiving medical treatment? If yes, for what illnesses? ◯ yes ◯ no

- Do you have or have you had...

◯ Heart disease
◯ **Blood disease**
◯ **Pacemaker**
◯ Stroke
◯ **Blood deficiency**
◯ Heart valve disease
◯ Endocarditis
◯ HIV
◯ other infections or diseases:

◯ Hormonal disorders
◯ Thyroid disease
◯ Sinusitis
◯ Rheumatism
◯ gastrointestinal disease
◯ kidney disease
◯ liver disease
◯ lung disease

◯ Diabetes
◯ Migraine
◯ Osteoarthritis
◯ Cancer
◯ Radiation, radiotherapy
◯ Chemotherapy
◯ Joint prostheses
◯ Tuberculosis

- Have you had any operations? If yes, which ones? ◯ yes ◯ no

- Do you smoke? If yes, how often and how much? ◯ yes ◯ no

- Do you drink alcohol regularly? If yes, how often and how much? ◯ yes ◯ no

- Do you use drugs? If yes, which ones and how often? ◯ yes ◯ no

- Are you pregnant? ◯ yes ◯ no
- Are you satisfied with the position of your teeth/smile? ◯ yes ◯ no
- Do you grind your teeth? ◯ yes ◯ no
- What is your treatment wish in our practice?

- How did you hear about our practice?

Questions?

Date: Signature: